GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
OPHTHALMIC STEROID-ANTIBIOTIC COMBINATIONS PA SUMMARY

Preferred	Non-Preferred
Neomycin/polymyxin B sulfate/dexamethasone generic Neomycin/polymyxin B sulfate/hydrocortisone generic Pred-G (prednisolone acetate/gentamicin) generic TobraDex (tobramycin 0.3%/dexamethasone 0.1%) TobraDex ST (tobramycin 0.3% /dexamethasone 0.05%) Zylet (0.5% loteprednol/0.3% tobramycin suspension)	Tobramycin 0.3%/dexamethasone 0.1% generic

LENGTH OF AUTHORIZATION: 1 month

PA CRITERIA:

Tobramycin 0.3%/Dexamethasone 0.1% Generic

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, brand TobraDex, TobraDex ST and at least one other preferred product, are not appropriate for the member.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.